99TH CONGRESS
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HOUSE OF REPRESENTATIVES

REPORT 99-80
Part 1

MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985

MAY 10, 1985.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

[To accompany H.R. 1868 which on April 2, 1985, was referred jointly to the Committee on Ways and Means and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 1868) to amend the Social Security Act to protect beneficiaries under the health care programs of that act from unfit health care practitioners, and otherwise to improve the antifraud provisions of that act, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; REFERENCES IN ACT.

(a) SHORT TITLE.—This Act may be cited as the "Medicare and Medicaid Patient and Program Protection Act of 1985".

(b) AMENDMENTS TO THE SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

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SEC. 2. EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128 (42 U.S.C. 1320a-7) is amended to read as follows:

"EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

"SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program:

"(1) CONVICTION OF PROGRAM-RELATED CRIMES.—Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program (as defined in subsection (h)).

"(2) CONVICTION RELATING TO PATIENT ABUSE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

"(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program:

"(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item, in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or financial abuse.

"(2) CONVICTION RELATING TO OBSTRUCTION OF AN INVESTIGATION.—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a).

"(3) CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of unlawful manufacture, distribution, prescription, or dispensing of a controlled substance or other criminal offense relating to a controlled substance.

"(4) LICENSE REVOCATION OR SUSPENSION.—Any individual or entity—

"(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license, for reasons bearing on the individual's or entity's professional competence, professional conduct, or financial integrity, or

"(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional conduct, or financial integrity.

"(5) EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under any Federal program, including programs of the Department of Defense or the Veterans' Administration, involving the provision of health care, or under a State health care program (as defined in subsection (h)).

"(6) CLAIMS FOR EXCESSIVE CHARGES OR UNNECESSARY SERVICES AND FAILURE OF CERTAIN ORGANIZATIONS TO FURNISH MEDICALLY NECESSARY SERVICES.—Any individual or entity that the Secretary determines—

"(A) has submitted or caused to be submitted bills or requests for payment under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's customary charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

"(B) has furnished items or services to patients (whether or not eligible for benefits under title XVIII or a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

"(C) is—

"(i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under title XIX, or

"(ii) an entity furnishing services under a waiver approved under section 1915(b)(1),

and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

"(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

"(7) Fraud, kickbacks, and other prohibited activities.—Any individual or entity that the Secretary determines has committed an act which is described in section 1128A or section 1128B.

"(8) Entities controlled by a sanctioned individual.—Any entity with respect to which the Secretary determines that a person—

"(A)(i) with an ownership or control interest (as defined in section 1124(a)(3)) in that entity, or

"(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity—

is a person—

"(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

"(ii) against whom a civil monetary penalty has been assessed under section 1128A; or

"(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

"(9) Failure to disclose required information.—Any entity that did not fully and accurately make any disclosure required of it by section 1124 or section 1126.

"(10) Failure to supply requested information on subcontractors and suppliers.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary—

"(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

"(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

"(11) Failure to supply payment information.—Any individual or entity furnishing items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

"(12) Failure to grant immediate access.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

"(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

"(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

"(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.—

"(D) To a State medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

"(13) FAILURE TO TAKE CORRECTIVE ACTION.—Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

Subject to subsection (d)(2), the Secretary shall exercise the authority under this subsection in a manner that results in an individual's or entity's exclusion from all the programs under title XVIII and all the State health care programs in which the individual or entity may otherwise participate.

"(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) An exclusion under this section or under section 1128A shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

"(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

"(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under title XVIII or under a State health care program for—

"(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

"(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion,

until the passage of 30 days after the effective date of the exclusion.

"(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion under subsection (b)(12), the period) of the exclusion.

"(B) In the case of an exclusion under subsection (a)(1), the minimum period of the exclusion may not be less than five years.

"(C) In the case of an exclusion under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

"(i) the length of the period in which the individual or entity failed to grant the immediate access described in that subsection, and

"(ii) an additional period, not to exceed 90 days, set by the Secretary.

"(d) NOTICE TO STATE AGENCIES AND EXCLUSION UNDER STATE HEALTH CARE PROGRAMS.—(1) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General)—

"(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1128A, and

"(B) the period (described in paragraph (2)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

"(2)(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (1) shall be the same as any period of exclusion under a program under title XVIII.

"(B) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (1) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

"(e) NOTICE TO STATE LICENSING AGENCIES.—The Secretary shall—

"(1) promptly notify the appropriate State or local agency or authority, having the responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A, of the fact and circumstances of the exclusion,

"(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

"(3) request that the State or local agency or authority keep the Secretary and the Inspector General in the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.

"(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) Any individual or entity that is excluded (or directed to be excluded) from participation under this section (or is denied termination of the exclusion under subsection (g)) is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(2) The provisions of section 205(h) shall apply with respect to this section and sections 1128A and 1156 to the same extent as it is applicable with respect to title II.

"(g) APPLICATION FOR TERMINATION OF EXCLUSION.—(1) An individual or entity excluded (or directed to be excluded) from participation under this section (other than under subsection (b)(12)) or section 1128A may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1128A.

"(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

"(A) there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion, and

"(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

"(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

"(h) DEFINITION OF STATE HEALTH CARE PROGRAM.—For purposes of this section and sections 1128A and 1128B, the term 'State health care program' means—

"(1) a State plan approved under title XIX,

"(2) any program receiving funds under title V or from an allotment to a State under such title, or

"(3) any program receiving funds under title XX or from an allotment to a State under such title.".

SEC. 3. CIVIL MONETARY PENALTIES.

(a) GROUNDS FOR IMPOSITION.—(1) Subsection (a)(1) of section 1128A (42 U.S.C. 1320a-7a) is amended by striking out "the Secretary determines" and all that follows through "; or" and inserting in lieu thereof "the Secretary determines—

"(A) is for a medical or other item or service that the person knows or has reason to know was not provided as claimed,

"(B) is for a medical or other item or service and the person knows or has reason to know the claim is false or fraudulent,

"(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or has reason to know that the individual who furnished (or supervised the furnishing of) the service—

"(i) was not licensed as a physician,

"(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

"(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified, or

"(D) is for a medical or other item or service furnished during a period in which the person was excluded under the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1985), or 1866(b); or".

(2) Subsection (a)(2)(B) of such section is amended by inserting "(or other requirement of a State plan under title XIX)" after "State agency".

(3) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the programs under title XVIII and to direct the appropriate State agency to exclude the person from participation in any State health care program.".

(4) No civil penalty or assessment may be imposed under section 1128A(a) of the Social Security Act in the case of a claim filed before August 13, 1981, if liability for the amount of the penalty or assessment could not have been imposed with respect

to the claim under section 3729 of title 31, United States Code (relating to false claims).

(b) STATUTE OF LIMITATION ON ACTIONS.—Subsection (b)(1) of such section is amended by adding at the end the following new sentences: "The Secretary may not initiate an action under this section with respect to any claim later than six years after the date the claim was presented. The Secretary may initiate an action under this section by personal service or by mailing, by registered or certified mail, the notice required by paragraph (2).".

(c) CONFORMING AMENDMENT.—Subsections (b), (c), (f), and (g) of such section are each amended by striking out "penalty or assessment" and inserting in lieu thereof "penalty, assessment, or exclusion" each place it appears.

(d) PRO-RATED PAYMENT OF RECOVERIES TO STATE AGENCIES.—Subsection (e)(1)(A) of such section is amended by striking out "equal to the State's share of the amount paid by the State agency" and inserting in lieu thereof "bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid".

(e) NOTICE TO STATE AGENCIES.—Subsection (g) of such section is further amended by inserting "the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h))," after "professional organization,".

(f) APPLICATION OF SUBPOENA POWER AND INJUNCTIVE POWERS.—Such section is further amended by adding at the end the following new subsections:

"(i) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II.

"(j) Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, or encumbering assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.".

SEC. 4. CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) TECHNICAL AMENDMENTS.—Section 1909 (42 U.S.C. 1396h) is amended—

(1) by amending the heading to read as follows:

"CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS";

(2) in subsection (a)(1), by striking out "a State plan approved under this title" and inserting in lieu thereof "a program under title XVIII or a State health care program (as defined in section 1128(h))";

(3) in the matter in subsection (a) following paragraph (4), by striking out "this title" the first place it appears and inserting in lieu thereof "the program";

(4) in the last sentence of subsection (a), by striking out "this title" the first place it appears and inserting in lieu thereof "title XIX", and by striking out "this title" the second place it appears and inserting in lieu thereof "that title";

(5) in paragraphs (1)(A), (1)(B), (2)(A), (2)(B), and (3)(A) of subsection (b), by striking out "this title" and inserting in lieu thereof "title XVIII or a State health care program" each place it appears;

(6) in subsection (c), by striking out "or home health agency (as those terms are employed in this title)" and inserting in lieu thereof "home health agency, or other entity for which certification is required under title XVIII or a State health care program"; and

(7) in subsection (d), by striking out "this title" and inserting in lieu thereof "title XIX" each place it appears.

(b) CRIMINAL PENALTIES FOR PHYSICIAN MISREPRESENTATIONS.—Subsection (a) of such section is further amended—

(1) by striking out "or" at the end of paragraph (3),

(2) by inserting "or" at the end of paragraph (4), and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a program under title XVIII or a State health care program and knows that the individual who furnished the service either—

"(A) was not licensed as a physician, or

"(B) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing),".

(c) Redesignation of Section 1877(d) as Section 1128B(e). Subsection (d) of section 1877 (42 U.S.C. 1395nn) is redesignated as subsection (e) and is transferred and inserted in section 1909 at the end thereof.

(d) Redesignation of Section 1909 as Section 1128B.—Section 1909, as amended by subsections (a), (b) and (c) of this section, is redesignated as section 1128B and is transferred to title XI and inserted immediately after section 1128A.

(e) Repeal.—Section 1877 (other than subsection (d) thereof whioh was transferred under subsection (c) of this section) is repealed.

SEC. 5 INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS.

(a) Medicaid Plan Requirement.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking out "and" at the end of paragraph (45),

(2) by striking out the period at the end of paragraph (46) and inserting in lieu thereof "; and", and

(3) by inserting after paragraph (46) the following new paragraph:

"(47) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1919.".

(b) Information Required.—Title XIX is amended by adding at the end of the following new section:

INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAISNT HEALTH CARE PRACTITIONERS AND PROVIDERS

"Sec. 1919. (a) Information Reporting Requirement.—The requirement referred to in section 1902(a)(47) is that the State must provide for the following:

"(1) Information Reporting System.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners or entities:

"(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

"(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

"(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

"(2) Access to Documents.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions nd determinations described in such paragraph for the purpose of carrying out this Act.

"(b) Form of Information.—The information described in subsection (a)(1) shall be provided to the Secretary (or, under suitable arrangements made by the Secretary, to another entity) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information—

"(1) to licensing authorities described in subsection (a)(1),

"(2) to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),

"(3) to utilization and quality control peer review organizations described in part B of title XI, and

"(4) to State medicaid fraud control units (as defined in section 1903(q)),

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

"(c) Confidentiality of Information Provided.—The Secretary shall provide for suitable safeguards for the confidentiality of such of the information furnished under subsection (a) as is not otherwise available to the public.".

SEC. 6. OBLIGATION OF HEALTH CARE PRACTITIONERS AND PROVIDERS.

Section 1156 (42 U.S.C. 1320c-5) is amended—

"(1) by striking out "title XVIII" and "such title" in subsection (a) and inserting in lieu thereof "this Act" in each instance, and

"(2) by striking out "title XVIII" in subsection (b) and inserting in lieu thereof "this Act" each place it appears.

SEC. 7. EXCLUSION UNDER THE MEDICAID PROGRAM.

Section 1902 (42 U.S.C. 1396b) is amended by inserting after subsection (f) the following new subsection:

"(g)(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this title for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII under section 1128, 1128A, or 1866(b)(2).

"(2) In order for a State to receive payments for medical assistance under section 1903(a), with respect to payments the State makes to a health maintenance organization (as defined in section 1903(m)) or to an entity furnishing services under a waiver approved under section 1915(b)(1), the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

"(A) could be excluded under section 1128(b)(8) (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions), or

"(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B).

"(3) As used in this subsection, the term 'exclude' includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.".

SEC. 8. MISCELLANEOUS AND CONFORMING AMENDMENTS.

(a) Maternal and Child Health Program.—Section 504(b) (42 U.S.C 704(b)) is amended—

(1) by striking out "or" at the end of paragraph (4),

(2) by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; or", and

(3) by adding at the end thereof the following new paragraph:

"(6) payment for any item or service furnished by an individual or entity excluded from participation in the program under this title pursuant to section 1128 or section 1128A.".

(b) Disclosure Requirements.—(1) Subsection (a) of section 1126 (42 U.S.C. 1320a-5) is amended—

(A) in the first sentence, by striking out "or other institution" and all that follows through the period at the end and inserting in lieu thereof "or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person that is a person described in subparagraphs (A) and (B) of section 1128(b)(8).", and

(B) in the second sentence, by striking out "institution, organization, or agency" and inserting in lieu thereof "entity".

(2) Subsection (b) of such section is amended by striking out "institution, organization, or agency" and inserting in lieu thereof "entity" each place it appears.

(c) Medicare Payments.—(1) Section 1862 (42 U.S.C. 1395y) is amended—

(A) by striking out subsection (d), and

(B) by amending subsection (e) to read as follows:

"(e) No payment may be made under this title with respect to any item or service furnished by an individual or entity during any period when the individual or entity is excluded from participation in a program under this title pursuant to section 1128 or section 1128A.".

(2) Section 1842(j) (42 U.S.C. 1395u(j)) is amended—

(A) in paragraph (2)—

(i) by amending subparagraph (A) to read as follows:

"(A) excluding a physician from participation in the programs under this title for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128, or", and

(ii) by striking out "barred from participation in the program" in the second sentence and inserting in lieu thereof "excluded from participation in the programs"; and

(B) by striking out "bar" in paragraph (3)(A) and inserting in lieu thereof "exclude".

(3) Section 1862(h)(4) (42 U.S.C. 1395y(h)(4)) is amended by striking out "paragraphs (2) and (3) of subsection 1862(d)" and inserting in lieu thereof "subsections (c), (f), and (g) of section 1128".

(4) Paragraph (3) of section 1886(f) (42 U.S.C. 1395ww(f)) is amended to read as follows:

(3) The provisions of subsections (c) through (g) of section 1128 to apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1128(b)(13).".

(d) Termination of Provider Agreements Under Medicare.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by striking out paragraph (3) of subsection (a);

(2) by amending subsection (b) to read as follows:

"(b) (1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

"(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

"(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

"(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, or

"(C) has excluded the provider from participation in a program under this title pursuant to section 1128 of section 1128A.

"(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall be effective on the same date, and with respect to the same items and services, as an exclusion from participation under the programs under this title would become effective under section 1128(c).";

(3) in paragraphs (1) and (3) of subsection (c), by striking out "an agreement filed under this title by a provider of services has been terminated by the Secretary" and inserting in lieu thereof "the Secretary has terminated or has refused to renew an agreement under title with a provider of services";

(4) by inserting "or nonrenewal" in subsection (c) after "termination" each place it appears; and

(5) by adding at the end the following new subsection:

"(g) (1) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.".

"(e) Conforming Amendment.—Section 1869 (42 U.S.C. 1395ff) is amended by striking out subsection (c).

"(f) Medicaid Plan Revisions.—Section 1902(a) (42 U.S.C. 1396b(a)) is amended—

(1) in paragraph (23), by inserting "subsection (g) and in" after "except as provided in",

(2) in paragraph (38), by striking out "respectively, (A)" and all that follows up to the semicolon at the end and inserting in lieu thereof "the information described in section 1128(b)(9)", and

(3) in paragraph (39)—

(A) by striking out "bar" and inserting in lieu thereof "exclude",

(B) by striking out "person" and inserting in lieu thereof "individual or entity" each place it appears, and

(C) by inserting "or section 1128A" after "section 1128".

(g) Denial of Federal Financial Participation Under Medicaid.—Paragraph (2) of section 1903(i) (42 U.S.C. 1396b(i)) is amended to read as follows:

"(2) with respect to any amount expended for items or services furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation in the State plan under this title pursuant to section 1128 or section 1128A; or".

(h) OTHER MEDICAID CONFORMING AMENDMENTS.—(1) Subsection (n) of section 1903 (42 U.S.C. 1396b) is repealed.

(2) Paragraph (2) of section 1915(a) (42 U.S.C. 1396n(a)) is amended to read as follows:

"(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

"(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

"(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.".

(i) TITLE XX.—Section 2005(a) (42 U.S.C. 1397d(a)) is amended–

(1) by striking out "or" at the end of paragraph (7),

(2) by striking out the period at the end of paragraph (8) and inserting in lieu thereof "; or", and

(3) by adding at the end thereof the following new paragraph:

"(9) for payment for any item or service furnished by a person excluded from participation in the program under this title pursuant to section 1128 or section 1128A.".

(j) DENIAL, REVOCATION, OR SUSPENSION OF REGISTRATION TO MANUFACTURE, DISTRIBUTE, OR DISPENSE A CONTROLLED SUBSTANCE FOR ENTITIES EXCLUDED FROM THE MEDICARE PROGRAM.—Section 304(a) of the Controlled Substances Act (21 U.S.C. 824(a)) is amended—

(1) by striking out "or" at the end of paragraph (3),

(2) by striking out the period at the end of paragraph (4) and inserting in lieu thereof "; or", and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) has been excluded (or directed to be excluded) from participation in a program pursuant to section 1128(a) of the Social Security Act.".

SEC. 9. CLARIFICATION OF MEDICAID MORATORIUM PROVISIONS OF DEFICIT REDUCTION ACT OF 1984.

Section 2373(c) of the Deficit Reduction Act of 1984 (Public Law 98-369; 98 Stat. 1112) is amended—

(1) in paragraph (1)—

(A) by inserting "(whether or not approved)" after "such State's plan",

(B) by inserting "(including any part of the plan operating pursuant to section 1902(f) of that Act), or the operation thereunder," after "Social Security Act", and

(C) by inserting "(or its operation's)" after "such plan's"; and

(2) by adding at the end the following new paragraph:

"(5) In this subsection, a State plan is considered to include any amendment or other change in the plan which is submitted by a State, or for which the Secretary otherwise has notice, whether before or after the date of enactment of the Deficit Reduction Act of 1984 and whether or not the amendment or change was approved, disapproved, acted upon, or not acted upon by the Secretary.".

SEC. 10. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsections (b), (c), (d), and (e), the amendments made by this Act shall become effective at the end of the 14-day period beginning on the date of the enactment of this Act and shall not apply to administrative proceedings commenced before the end of such period.

(b) MANDATORY MINIMUM EXCLUSIONS APPLY PROSPECTIVELY..—Section 1128(c)(3)(B) of the Social Security Act (as amended by this Act), which requires an exclusion of not less than five years in the case of certain exclusions, shall not apply to exclusions based on convictions occurring before the date of the enactment of this Act.

(c) EFFECTIVE DATE FOR CHANGES IN MEDICAID LAW.—(1) The amendments made by sections 5 and 8(f) apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning more than 30 days after the date of the enactment of this Act.

(2) In the case of State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these addtional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(3) Subsection (j) of section 1128A of the Social Security Act (as added by section 3(f) of this Act) takes effect on the date of the enactment of this Act.

(d) Physician Misrepresentations.—Clauses (ii) and (iii) of section 1128A(a)(1)(C) of the Social Security Act, as amended by section 3(a)(1)(F) of this Act, and subparagraph (B) of section 1128B(a)(5) of the Social Security Act, as amended by section 4(b)(3) of this Act, apply to claims presented for services performed on or after the effective date specified in subsection (a), without regard to the date the misrepresentation of fact was made.

(2) Clarification of Medicaid Moratorium.—The amendments made by section 9 apply as though they were originally included in the enactment of section 2373(c) of the Deficit Reduction Act of 1984.

(f) Treatment of Certain Denials of Payment.—For purposes of section 1128(b)(8)(B)(iii) of the Social Security Act (as amended by section 2 of this Act), a person shall be considered to have been excluded from participation under a program under title XVIII if payment to the person has been denied under section 1862(d) of the Social Security Act, as in effect before the effective date specified in subsection (a).

I. Introduction

PURPOSE

The Committee bill H.R. 1868, the Medicare and Medicaid Patient and Program Protection Act of 1985, would recodify certain provisions of law relating to medicare and medicaid fraud and abuse and extend them to the maternal and child health program and the title XX social services program. The bill would also add several new provisions. It would require a minimum exclusion of five years for individuals or entities convicted of a program-related crime. It would also mandate the exclusion of any individual or entity convicted of a crime related to patient neglect or abuse. In addition, it would authorize the Secretary to exclude from medicare, medicaid, the maternal and child health program and the title XX social services program any individual or entity convicted of certain crimes related to the provision of health services, to financial integrity, to the obstruction of certain investigations or to controlled substance violations and would authorize the exclusion from medicare, medicaid and the State health care programs in all States a person whose license had been revoked or suspended by any State licensing authority.

The purpose of the recodification is to organize, clarify and simplify current provisions related to offenses for fraud and abuse under medicare and medicaid. Further, the additional authority for the Secretary to exclude certain practitioners who have committed crimes or lost their licenses is intended to fill in gaps in the current ability of the Department of Health and Human Services to protect medicare, medicaid and other program beneficiaries from incompetent practitioners and receiving inappropriate care.

SHORT SUMMARY

H.R. 1868 would give the Secretary the authority to:

Exclude from medicare, and direct the States to exclude from medicaid, the maternal and child health programs under title V and the title XX social services programs any individual or entity convicted of a program-related crime for a minimum of five years;

Exclude from medicare and direct the States to exclude from the above State health care programs any individual or entity convicted of a criminal offense relating to neglect or abuse of patients;

Exclude from medicare and direct the States to exclude from the State health care programs any individual or entity convicted of certain offenses including fraud, financial abuse or unlawful manufacture or distribution of a controlled substance;

Exclude from medicare and direct the States to exclude from the State health care programs any individual or entity whose license to provide health care has been revoked, suspended or who has otherwise lost or surrendered such a license for reasons bearing on professional competence, professional conduct or financial integrity;

Exclude a health maintenance organization, approved under medicare or medicaid, which has failed substantially to provide medically necessary items or services as required by law or contract if such failure has or has the likelihood of adversely affecting beneficiaries under these programs;

·Impose a civil monetary penalty on a person who submits a claim for a physician's service and such physician was not licensed, had obtained a license through a misrepresentation of a material fact or who claimed to be board certified and was not; in addition, such person would be subject to a criminal penalty;

In addition, H.R. 1868:

Would amend the Controlled Substance Act to permit the Attorney General to deny, revoke, or suspend the registration to manufacture, distribute or dispense a controlled substance for any individual or entity excluded from the medicare program for acts requiring mandatory exclusions;

Require each State to report to the Secretary the following information relating to formal proceedings concluded against a health care practitioner by a State licensing authority; (1) any adverse actions taken; (2) any dismissal or closure of such proceeding because the license was surrendered or the individual or entity left the State; or (3) any other loss of license.

BACKGROUND AND NEED FOR LEGISLATION

Under current law, the Department of Health and Human Services (HHS) can exclude practitioners from participation in medicare for a number of reasons:

Conviction of a criminal act against medicare (title XVIII), medicaid (title XIX) or title XX of the Social Security Act;

Imposition of a civil monetary penalty for acts against medicare or medicaid;

Submitting false claims to medicare;

Repeatedly providing more services than necessary to medicare beneficiaries;

Submitting medicare claims with changes that substantially exceed the practitioner's customary charges;

Providing services to medicare beneficiaries that are of a quality which fails to meet professionally recognized standards of care;

Failing to keep adequate records to demonstrate the need for services rendered.

HHS has the authority to require all States to exclude practitioners from participating in medicaid only when the practitioner is convicted of a criminal act against medicare, medicaid or title XX, or where HHS has imposed a civil monetary penalty on the practitioner for acts against medicare or medicaid.

If HHS excludes a practitioner for the above reasons, HHS is required to notify the State and local agencies responsible for health care licensing or certification of the suspension, and request that they invoke sanctions in accordance with applicable State law or policy.

In the last quarter of fiscal year 1983, Secretary Heckler transferred to the Inspector General's (IG) Office from the Health Care Financing Administration (HCFA) the authority to suspend or terminate from medicare and medicaid all health care providers who engage in fraudulent or abusive practices. During the same period, the Civil Monetary Penalty Law (CMPL), providing tough monetary sanctions, was formally implemented by the Department, further enpowering the IG take action against health providers who abuse or defraud these programs.

On May 1, 1984, the U.S. General Accounting Office (GAO) issued a report to the Secretary of HHS which concluded that there was a need to expand Federal authority to protect medicare and medicaid patients from health practitioners who lose their licenses. The GAO report found that medicare and medicaid patients are being treated in some States by health care practitioners whose licenses were revoked or suspended by another State's licensing board because they did not meet minimum professional standards. This occurred because practitioners can move to another State where they have a license and continue to practice. Such practitioners are able to treat medicare and medicaid patients because HHS does not have the authority to exclude them from these programs in all States based on licensing board findings and sanctions in one State. Currently, HHS is only empowered to exclude the practitioner in the State in which he or she has lost a license.

Licensing of health care professionals is a responsibility of the States, and practitioners can hold licenses in more than one State. HHS administers medicare and medicaid at the Federal level. To participate in these programs, a practitioner must hold a valid State license. When a State licensing board revokes or suspends a practitioner's license, he or she can no longer legally provide services in that State, and the State licensing boards makes medicare and medicaid aware of this fact, However, sanctioning action by one State does not automatically result in sanctioning by other States where the practitioner holds licenses.

A primary reason sanctioned practitioners were able to move to other States and continue practice was that other States did not learn of the practitioner's previous offenses, or when they did, many months or years had passed. When States are informed, it takes up to three years to sanction practitioners because procedures are lengthy and there is a shortage of personnel. In addition, State licensing laws may preclude a State from taking action based solely on another State's sanction. Further, physicians whose licenses have been revoked can enter the armed services and practice without a license from the State in which they are located.

Under current law, HHS can exclude practitioners only for acts committed against medicare, medicaid and their beneficiaries. As a result, HHS excludes relatively few of those sanctioned by State boards. For example, while State licensing boards in Michigan, Ohio and Pennsylvanai sanctioned 328 practitioners between 1977 and 1982, HHS nationwide excluded only 335 practitioners from 1975 to 1982. Also, only 15 of the 328 practitioners sanctioned by the three States were also excluded by HHS.

Further, over seventy percent (70%) of HHS exclusion actions were for criminal violations against the programs. However, fifty-eight percent (58%) of the 328 licensing board sanctions in the three States were for problems that affected the practitioners' ability to meet minimum professional standards to provide quality care.

In addition, HHS is unable to bar individuals or entities from participation that have been convicted of defrauding private health insurers or defrauding other Federal, State or local government programs.

In summary, HHS currently does not have the authority to exclude individuals or entities from medicare, medicaid, the maternal and child health program and title XX social services program who have been convicted of non-program related crimes such as fraud, financial abuse, neglect of patients or unlawful distribution of a controlled substance. It does not have the authority in all cases to exclude those who have been sanctioned for defrauding or abusing the medicaid program from participation in medicare or vice versa. Further, HHS does not have the authority to exclude nationwide those individuals or entities that have lost their licenses to provide health care or have otherwise been sanctioned by a State licensing authority.

II. EXPLANATION AND JUSTIFICATION

SECTION 2. EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS

Mandatory exclusion for program-related crimes (section 1128(a)(1) of the Social Security Act)

The Secretary would be required to exclude from participation in medicare and to direct the States to exclude from medicaid, the maternal and child health program and the title XX social services program, any individual or entity convicted of a criminal offense related to their participation in these programs. The exclusion would be for a period of not less than five years.

If the Secretary excludes an individual or entity from medicare under this provision, the State would be required to exclude such individual or entity from participation in medicaid, the maternal and child health program under title V, and the title XX social services program for a similar period. (Hereafter, medicaid, the maternal and child health program, and the title XX social services programs are referred to as the State health care programs.)

If an individual or entity convicted of a program-related offense involving a State health care program has not been furnishing services to medicare beneficiaries but would be eligible to do so, it is the Committee's expectation that the Secretary would proceed to exclude the individual or entity from medicare and then direct the States to exclude the party from the State health care programs.

If the individual or entity is a type of provider that would not otherwise be eligible for medicare payment, the Secretary could call these matters to the attention of the States and urge that they institute exclusion proceedings. In the alternative, the Secretary could follow the exclusion procedure for medicare and direct the States to exclude the provider from the State health care programs.

While there is currently a mandatory exclusion from medicare and medicaid for crimes related to medicare, medicaid or title XX, there is no minimum period of exclusion specified in the law. This provision would amend current law to require a minimum exclusion of five years for such crimes. The Committee believes that such a minimum exclusion is appropriate given the seriousness of the offenses. The minimum exclusion of five years provides the Secretary with adequate opportunity to determine whether there is a reasonable assurance that the types of offenses for which the individual or entity was excluded have not and will not recur. Moreover, a mandatory five-year exclusion should provide a clear and strong deterrent against the commission of criminal acts.

This provision would also extend current law to require mandatory exclusion from the maternal and child health and title XX

Social Services programs of individual or entities convicted of program-related crimes.

Mandatory exclusion for crimes related to patient neglect or abuse (section 1128(a)(2) of the Social Security Act)

The Secretary would be required to exclude from participation in medicare any individual or entity that has been convicted of a criminal offense relating to neglect or abuse of patients in connection with the delivery of health care.

If the Secretary excludes any individual or entity under this provision, the State would be required to exclude such individual or entity from participation in State health care programs for the same period.

As noted above, the Secretary could exclude from medicare providers who are eligible to but do not participate. In addition, she could direct States to exlude providers who are not otherwise eligible to participate in medicare.

Under current law, the Secretary does not have the authority to exclude persons who have been convicted of criminal offenses that are not related to medicare or other State health care programs. This provision would give the Secretary the authority to protect medicare and the State health care program beneficiaries from individuals or entities that have already been tried and convicted of offenses which the Secretary concludes entailed or resulted in neglect or abuse of other patients and whose continued participation in medicare and the State health care programs would, therefore, constitute a risk to the health and safety of patients in those programs.

The Committee believes that such exclusion should be mandatory based on the potential for serious harm to program beneficiaries presented by such individuals or entities. While the Committee has not made this provision subject to the mandatory five-year minimum exclusion period, the Committee expects that exclusions imposed under this provision will be for a period of five years or more, except in instances where mitigating factors justify a lesser period.

Permissive exclusions

Subsections 1128(b)(1) through (13) would establish discretionary authority for the Secretary to exclude individuals and entities from medicare for specified reasons. Although the Secretary would have discretion as to whether to initiate an exclusion proceeding in any particular case, the bill makes it clear that, if the Secretary concluded that an exclusion was warranted, these authorities would have to be exercised in a manner that resulted in the exclusion of the individual or entity from all of the medicare and State health care program for which the individual or entity was otherwise eligible to participate.

If the provider is eligible to participate in medicare, the Secretary would exclude the provider from medicare (even if such provider was not participating in medicare) and would simultaneously direct the States to exclude the provider from the State health care programs for a similar period of time. If the provider is not eligible to participate in medicare because such provider is the type of provider that is not reimbursed under that program, the Secretary could use the medicare exclusion procedures to direct the States to exclude the provider from the State health care programs for the period of time for which such provider would have been excluded from medicare.

Authority to exclude for conviction relating to fraud (section 1128(b)(1) of the Social Security Act)

The Secretary would be authorized to exclude any individual or entity convicted of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or financial abuse in connection with the delivery of health care or with respect to a program that is financed, at least partially, by any Federal, State or local government.

Under current law, the Secretary does not have the authority to exclude individuals or entities convicted of criminal offenses that are not related to the medicare or the State health care programs. This provision would permit the Secretary to exclude such persons and entities who have already been tried and convicted of offenses relating to their financial integrity, if the offenses occurred in delivering health care to other patients or if they occurred during participation in any other governmental programs.

Authority to exclude for conviction relating to obstruction of an investigation (section 1128(b)(2) of the Social Security Act)

The Secretary would be authorized to exclude any individual or entity convicted of interference or obstruction of any investigation into any criminal offense for crimes that would require mandatory exclusion under section 1128(a) or permit exclusion under section 1128(b)(1).

Authority to exclude for conviction relating to controlled substance (section 1128(b)(3) of the Social Security Act)

The Secretary would be authorized to exclude any individual or entity convicted of unlawful manufacture, distribution, or dispensing of a controlled substance or any other criminal offense relating to a controlled substance.

Authority to exclude for license revocation or suspension (section 1128(b)(4) of the Social Security Act)

The Secretary would be authorized to exclude any individual or entity whose license to provide health care has been suspended or revoked by a State licensing authority or whose license has otherwise been lost for reasons bearing on the individual's professional competence, professional conduct or financial integrity.

The Committee heard substantial testimony from the General Accounting Office, based on its investigation in three States, and from the Inspector General of HHS about the need to protect medicare and medicaid beneficiaries from practitioners who lose their license in one State, move to another State and continue to treat beneficiaries. This provision would permit the Secretary to exclude such persons from medicare in all States and to require the States to exclude them from participation in any State health care program.

This provision would also permit the exclusion of individuals or entities who surrender their licenses while disciplinary proceedings involving professional competence, professional conduct or financial integrity are pending. This provision will prevent unfit practitioners from avoiding exclusion through the expedient surrendering their license before the State can conclude proceedings against them.

Authority to exclude for exclusion from Federal health care programs (section 1128(b)(5) of the Social Security Act)

The Secretary would be authorized to exclude any individual or entity suspended or excluded from any Federal program involving the provision of health care. Programs included would be those administered by the Department of Defense or the Veterans Administration, as well as medicaid and the other State health care programs.

This provision is designed to correct the current anomaly whereby individuals or entities who have been found unfit to participate in one Federal health program or Federally-funded State health care program may continue to participate in medicare and the State health care programs. The Committee beleives that once such an individual or entity is found to be unfit to participate in one such program, they should be banned from participation in medicare and the State health care programs as well.

Authority to exclude for excessive charges, unnecessary services, or failure of certain organizations to furnish medically necessary services (section 1128(b)(6) of the Social Security Act)

The Secretary would be authorized to exclude any individual or entity the Secretary determines:

(1) submitted requests for payment which contain charges (or costs) substantially in excess of customary charges (or costs);

(2) furnished items or services substantially in excess of the patient's needs or a quality that fails to meet professionaly recognized standards of health care; or

(3) is a health maintenance organization, approved under medicare or medicaid, which has failed substantially to provide medically necessary items or services as required by law or contract if the failure has adversely affected or has the likelihood of adversely affecting medicare or medicaid beneficiaries.

The first two items of this provision essentially recodify current law under section 1862(d) which requires denial of medicare payment to persons committing any of these acts. The provision expands current law to include the State health care programs. Further, the provision would make it clear that where excess services were furnished or where there was a failure to provide quality care the Secretary could examine the provider's health care practices in furnishing services to patients who are not program beneficiaries.

The new provisions affecting health maintenance organizations (HMOs) and competitive medical plans (CMPs) are intended to deal with serious failures to abide by acceptable standards of medical practice, rather than isolated cases of inadvertant omissions. The Committee intends for the Secretary to examine whether there was a deliberate omission or a pattern of failing to provide necessary items and services, the seriousness of the effect on or risk to patients, and the reasons or circumstances involved. It is also expected that the practice standards used to determine that items or services were medically necessary would be based on generally accepted HMO practice standards. The Committee expects that these standards could be developed by physicians involved with prepaid group practices, other HMOs and CMPs, or standards used by State agencies that have contracts with HMOs.

Authority to exclude fraud, kickbacks, and other prohibited activities (section 1128(b)(7) of the Social Security Act)

The Secretary would be authorized to exclude any individual or entity which has committed an act subject to criminal penalty under the new section 1128B relating to kickbacks and bribes.

Under current law, a person may be subject to imprisonment or fine under section 1909 or 1877 if they have committed certain acts relating to kickbacks, bribes or false statements. This provision recodifies these provisions and permits sanctions and exclusions not only for medicare but also for the other State health care programs.

Authority to exclude entities controlled by a sanctioned individual (section 1128(b)(8) of the Social Security Act)

The Secretary would be authorized to exclude any entity that has a person with an ownership or controlling interest, or who has an officer, director, agent or managing employee that has been convicted or certain program-related offenses (described in section 1128(a) or section 1128(b) (1) (2) or (3)), or against whom a civil monetary penalty has been assessed, or who has been excluded from participation in medicare or a State health care program.

This section recodifies section 1128(b) of current law with respect to excluded entities from medicare which have a close relationship to individuals who have been excluded or sanctioned by the program on the basis of a program-related conviction. It also recodifies section 1128(c) of current law with respect to the exclusion of entities that have a person against whom a civil monetary penalty has been assessed. This provision expands the exclusion authority to include entities which have a close relationship with individuals who have been excluded from medicare or the other State health care programs.

Authority to exclude for failure to make certain disclosures (section 1128(b) (9), (10), and (11) of the Social Security Act)

The Secretary would be authorized to exclude any individual or entity which fails fully and accurately to make any disclosure required regarding persons with ownership or control, or persons convicted of program-related crimes, or which fails to supply the Secretary as requested information pertaining to the ownership of a subcontractor or to significant business transactions. In addition, the Secretary would be permitted to exclude any individual or entity that fails to provide information that the Secretary determines is necessary to determine amounts payable or refuses to permit examiniation of its fiscal or other records as may be necessary to verify such information.

These provisions are essentially a recodification of current law under section 1866(b) (2)(C) and (6), with an expansion in the entities covered and an extension to include exclusions from the State health care programs.

Authority to exclude for failure to grant immediate access (section 1128(b)(12) of the Social Security Act)

The Secretary would be authorized to exclude an individual or entity that fails to grant, upon reasonable request, immediate access to the Secretary, State agent, Inspector General, or a State medicaid fraud control unit for the purpose of performing their statutory functions. The Secretary would be required to define by regulation what constitutes immediate access and reasonable request. The period of exclusion would be equal to the period during which access was denied and an additional period not to exceed 90 days as set by the Secretary.

Authority to exclude for failure to take corrective action (section 1128(b)(13) of the Social Security Act)

The Secretary would be authorized to exclude any hospital which fails to comply substantially with a corrective action necessary to prevent or correct inappropriate admissions or practice patterns under the prospective payment system if required to do so under the provisions of section 1886(f)(2) pertaining to the review and recommendations of a peer review organization. This provision clarifies the sanctions available under current law and extends them to include exclusions from the State health care programs.

Due process (section 1128(c)-(g) of the Social Security Act)

All mandatory and permissible exclusions under section 1128 and 1128A would be effective at such time and upon such reasonable notice to the public and to the individual or entity as may be specified in regulation. An exclusion would be effective on or after the effective date specified by the notice of exclusion.

In order to avoid disruptions in care that would be harmful to patients and to permit an orderly transfer to another provider, payment to an excluded provider would be permitted under medicare, medicaid, and a State health care program for up to 30 days for inpatient institutional services furnished to an individual admitted prior to the exclusion, and for home health services or hospice care furnished pursuant to a plan established before the date of the exclusion. The Secretary could stop payments for such patients sooner than 30 days after exclusion if the Secretary concluded that the risk to the health and safety of the patients was sufficiently serious to warrant a more immediate transfer to a different provider.

Under the bill, the notice of the exclusion under section 1128 or 1128A would be required to state the earliest date on which the individual or entity could be reinstated in medicare, medicaid and the other State health care programs. The period could not be less than five years for an exclusion under the program-related crimes provision in section 1128(a)(1).

The individual or entity excluded under section 1128 would be entitled to reasonable notice and opportunity for a hearing by the Secretary after the notice of exclusion and to judicial review of the Secretary's final decision. These are the same hearing and notice requirements provided under present law in sections 1862(d), 1128 and 1156.

There are currently several different procedural regulations governing the various provisions available to the Secretary to sanction individuals and entities. Although similar in many respects, the regulations vary sufficiently that affected parties can become confused about the correct, applicable procedures. Hence, the Committee bill consolidates these authorities, and the Committee understands that this administration will be consolidated under the responsibility of the Inspector General. The Committee intends that the Secretary will promulgate a uniform set of procedural.

The provisions of section 205(h) of the Social Security Act have been expressly incorporated in the bill to make clear that the review process provided for in the bill shall be the exclusive means of review for questions arising under this section (and under sections 1128A and 1156).

The Secretary would be required to notify promptly the appropriate State agencies of the exclusion from medicare under section 1128. Each State would be required to provide for exclusion from its State health care programs for the same period as the medicare exclusion under the section 1128 or 1128A, unless the State requested and received a waiver from the Secretary, based on a judgment that the exclusion will result in program beneficiaries not having adequate access to appropriate services.

This is essentially a restatement of current law with respect to notice. With respect to required State sanctions, the bill restates current law under section 1128(a) requiring States to exclude individuals and entities convicted of a program-related crime. With respect to section 1128A civil monetary penalties, States would be required to exclude the individual or entity, rather than the Secretary being permitted to decide whether to direct the States to exclude such individual or entity. For all other current and new offenses, the State would be required to exclude from State health care programs for the same period as the medicare exclusion. In addition, as under current medicare law, the Secretary would be permitted to waive the exclusion from the State health care program upon the request of the State.

An individual or entity excluded from participation under section 1128 or the section 1128A civil monetary penalty provisions woud be permitted to apply to the Secretary for reinstatement under medicare, and the State health care programs. The Secretary could reinstate such individual or entity if the Secretary determined that there was no basis for a continuation of the exclusion. The Secretary would consider the conduct of the applicant which occured after the date of the notice of the exclusion or which was unknown to the Secretary at the time of the exclusion. The Secretary would have to be satisfied that there were reasonable assurances that the actions which were the basis for the original exclusion have not recurred or would not recur.

This provision also amends current law to provide for administrative and judicial review of a denial of an application for reinstatement. The Committee believes that such review is appropriate in order to provide excluded individuals and entities a safeguard against the possibility of arbitrary denials of reinstatement.

The Committee intends that the Secretary will exercise due diligence in exercising the exclusionary authority within generally accepted procedural safeguards. As such, the Committee intends that the decision of the Secretary should be accorded deference in the judicial review process. The Committee also intends for the Secretary to set forth in regulations the frequency with which applications for reinstatement can be made in order to prevent unduly repetitious submission of such applications.

SECTION 3. CIVIL MONETARY PENALTIES (SECTION 1128A OF THE SOCIAL SECURITY ACT)

Under current law, the Secretary is authorized to impose a civil monetary penalty (of up $2,000 per item or service), plus as assessment of twice the amount claimed, on any person who files a claim for a medical or other item or service that the person knew or had reason to know was not provided as claimed. The Secretary is also authorized to exclude a person, against whom a civil money penalty or assessment has been imposed, from medicare and to direct his exclusion from medicaid as currently provided in section 1128(c). The Committee bill consolidates and clarifies these authorities, along with some expansion of the grounds for penalties and exclusion.

The bill makes several clarifying amendments to the civil monetary penalty statute. First, the bill amends the statute to make actionable those claims a person knew or had reason to know were "false or fraudulent." This provision is intended to clarify that the scope of the statute includes such conduct as double billing, but is not intended to change the current standard of proof regarding the requirement that a person knew or had reason to know the claim was wrongful.

The bill further clarifies the statute by expressly providing that the submission of claims for physician's services or items or services incident to a physician's service which are furnished or supervised by a non-licensed physician are actionable under the statute. In addition, the bill expands the statute's coverage to encompass claims for such items or services where the physician's license was obtained through material misrepresentations or where the physician falsely represented to the patient that he or she was board-certified in a medical specialty.

The Committee notes a clarification of intent with respect to the definition of "item of service" in section 1128A(h)(3) of the current statute. Since the enactment of the civil monetary penalty statute, the Congress has enacted the prospective payment system (PPS) for inpatient hospital services furnished under medicare (section 1886 of the Social Security Act). Consequently, hospitals now bill medicare for a hospital inpatient stay and receive a payment that encompasses all the hospital inpatient services furnished during that stay. This change in the mechanism and documentation by which hospitals make claims for services under PPS does not affect their status as claims for items or services within the meaning of section 1128A. Other examples of information that hospitals provide under PPS that may constitute a claim include diagnostic and procedural information, cost reports, reports on the numbers and time allocation of interns and residents, and length of stay information.

Under the bill, the Secretary's authority to exclude a person against whom a civil monetary penalty or assessment is imposed would be relocated from section 1128 to section 1128A. The intent of this change is to make explicit the policy that the Secretary may use a single administrative procedure both for imposition of penalties and assessments and for exclusions.

The Committee's bill, in the new section 1128(6)(7), would also authorize the Secretary to exclude an individual or entity who commits an act that would be a basis for a civil monetary penalty under section 1128A. Thus, the Committee bill would give the Secretary two alternative procedures for exclusion. The Secretary could use section 1128, which does not involve civil money penalties and for which the opportunity for hearing follows the notice of exclusion, or could use section 1128A, which combines actions for exclusion and civil money penalties and which offers an opportunity for hearing prior to the exclusion and penalty. It is the Committee's intent, however, that the Secretary choose one or the other alternative in each instance and that the Secretary not subject an individual or entity to both procedures on the same set of facts.

By consolidating the exclusion and penalty provisions in section 1128A, the bill would also provide a single forum for judicial review of such penalties, assessments and exclusions. Under current law, civil monetary penalties and assessments are subject to review by the Courts of Appeal; whereas, exclusions based on them under section 1128 are subject to review under Section 205(g) in the district courts.

In the case of claims filed before August 13, 1981 (the effective date of the civil monetary penalty law), the bill provides that no civil monetary penalty or assessment can be imposed in excess of what could have been imposed under the False Claims Act (31 U.S.C. 3729) for the same conduct. The intent of this provision is to clarify the standards applicable in proceedings under this statute involving such claims.

Under the bill, the Secretary would not be permitted to initiate an action under the civil monetary provisions later than six years after a claim had been presented. This is the same period provided in the False Claims Act (31 U.S.C. 3731). In addition, the section clarifies that actions may be initiated either by mailing notices by registered or certified mail, or by delivery to Respondent.

A State's share of funds collected under the civil monetary penalty statute in cases involving medicaid claims would be increased under the bill. Under current law, the State recovers only its share of the medicaid funds actually paid as a result of false claims. Under the bill, the State would be paid a portion of the total amount collected under the civil monetary penalty statute, in proportion to its share of the amount it paid for the claims on which the amount collected is based. The intent of this provision is to encourage States to develop and refer civil monetary penalty cases to the Secretary, and to recompense them for their investigative and support services in civil monetary penalty cases.

The bill would authorize the Secretary to issue and enforce subpoenas with respect to civil monetary penalty proceedings to the same extend the Secretary has such authority in other medicare and medicaid matters.

If the Secretary has evidence that any person has engaged, is engaging or is about to engage in any activity which makes the person subject to a civil monetary penalty, the Secretary would be permitted to bring an action in district court to enjoin such activity or to enjoin such persons from concealing, removing or encumbering assets which may be required in order to pay a civil monetary penalty, or to seek other appropriate relief, including receivership. This provision is modeled on the injunctive authorities of other government agencies with anti-fraud responsibilities, namely, the Securities and Exchange Commission (*See* 15 U.S.C. 77t) and the Federal Trade Commission (*See* 15 U.S.C. 53(b)). It is intended that district courts will grant the Secretary appropriate relief based on evidentiary showings which are no more burdensome than evidentiary showings required of those agencies.

SECTION 4. CRIMINAL PENALTIES FOR CERTAIN FRAUD AND ABUSE RELATED TO MEDICARE AND MEDICAID (SECTION 1128B OF THE SOCIAL SECURITY ACT)

The bill would relocate the kickback, bribe, and false statements provisions of medicare (currently section 1877) and medicaid (currently section 1909) into a new section 1128B. The scope of these offenses would be broadened to encompass the maternal and child health program and the Title XX social services program. This bill also would provide criminal penalties for persons presenting claims for physician's services when the person was not a licensed physician or got the license through a misrepresentation.

SECTION 5. INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS (SECTIONS 1902(a)47) AND 1919(C) OF THE SOCIAL SECURITY ACT)

A State would be required to have in effect a system of reporting informatioin with respect to formal proceedings concluded against an individual or entity by the State licensing authority.

The State would be required to maintain a reporting system on any adverse actions taken by such licensing authority, including any revocation or suspension of a license, reprimand, reason of the practitioner or entity surrending the license or leaving the State, also any other loss of license whether by operation of law, voluntary surrender, or otherwise.

The State would be required to provide the Secretary, or an entity designated by the Secretary, access to such information for the purpose of carrying out this Act. The information must be supplied to the Secretary or, under other suitable arrangements by the Secretary, to another entity in such a manner as determined by the Secretary. Information would be required to be provided to State licensing authorities and to other State health care programs as well.

The Committee believes that there are other organizations which are currently collecting information on revocation, suspension, censure, and other licensure action against health care professionals which the Secretary might determine could adequately perform collection functions on behalf of the medicare and medicaid programs. The Secretary may find that it is not necessary to duplicate these collection processes. Therefore, the bill would leave to the Secretary the discretion to determine who might appropriately collect the information. If the Secretary decides to use another organization for the collection and dissemination of information, it is incumbent upon the Secretary to ensure that any organization chosen can provide the information in a timely manner and in such a way as to be useful to the Secretary.

Further, the Committee believes that it would be an excessive burden for the Secretary to collect information on all actions commenced or still pending only for the collection of completed actions.

The Committee anticipates that the Secretary and the Inspector General of the Department of Health and Human Services may wish to utilize peer review organizations to review the actions of State boards in determining whether the loss of license involved professional competence, professional conduct or financial integrity.

The Secretary would be required to provide suitable safeguards to ensure the confidentiality of the information furnished by State licensing authorities.

SECTION 6. OBLIGATIONS OF HEALTH PRACTITIONERS AND PROVIDERS (SECTION 1156 OF THE SOCIAL SECURITY ACT)

The bill would amend section 1156 of the Social Security Act which currently sets forth the obligations of physicians and other practitioners treating medicare patients to provide quality of care which is medically necessary and appropriately documented, and provides for the exclusion from medicare of providers who, upon review and recommendation of a utilization and quality control peer review organization, are found to have violated those obligations. The provision would extend those obligations to encompass all health care services for which the payment may be made under the Social Security Act, not just medicare. Further, the exclusion authority would extend to encompass violations occurring in, and exclusions from, any health care program for which payment may be made under the Social Security Act.

SECTION 7. EXCLUSION UNDER THE MEDICAID PROGRAM

The provision would give the States the express authority to exclude or otherwise bar individuals or entities from participation in State title XIX programs for any of the reasons that constitute a basis for an exclusion from title XVIII under Sections 1128, 1128A or 1866(b)(2). This provision is not intended to preclude a State from establishing any other bases for excluding individuals or entities from its title XIX program by State law.

SECTION 8. MISCELLANEOUS AND CONFORMING AMENDMENTS

Denial, revocation or suspension of registration to manufacture, distribute or dispense a controlled substance

The bill would amend the Controlled Substance Act to add as a basis for the denial, revocation or suspension of registration to manfacture, distribute or dispense a controlled substance by the Attorney General, any individual or entity that has been excluded, (or directed to be excluded) from participation in a program pursuant to section 1128(a).

The bill would amend titles V (maternal and child program), XIX (medicaid) and XX (social services program) to clarify that no payment could be made for any item or service furnished by an individual or entity excluded from participation in those programs.

The bill would also amend title XVIII (medicare) to provide that an institution or agency would not be entitled to separate notice and an opportunity for a hearing under both section 1128 and section 1866(b)(2) (termination of provider agreements) with respect to a determination or determinations based on the same underlying facts and issues.

In addition, it makes other technical and conforming amendments to the Social Security Act.

SECTION 9. CLARIFICATION OF MEDICAID MORATORIUM PROVISIONS

Section 9 of the bill would clarify the medicaid moratorium provision in section 2373(c) of the Deficit Reduction Act of 1984 (P.L. 98-369).

Effective dates

In general, the amendments would be effective at the end of the 14-day period beginning on the date of enactment. While the Secretary's new exclusionary authority becomes effective 14 days after enactment, the convictions which can now serve as a ground for exclusion could have occurred prior to the enactment of this bill. In addition, some grounds for exclusion are already contained in current law and these would not be affected by the bill with respect to claims filed prior to enactment.

The provision which would require a minimum exclusion of five years would not apply to exclusions based on convictions occurring before the date of the enactment of this Act.

The effective date for changes in the medicaid law would be for calendar quarters beginning more than 30 days after enactment. In the case of a State plan which the Secretary determines would require State legislation in order to meet the additional requirements herein imposed, the State plan would not be regarded as failing to comply with requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

The subpoena and injunctive provision would be effective on the date of enactment.

The provision involving physician misrepresentations would only apply to claims filed after the effective date of this legislation. However, some physician misrepresentations are already subject to sanctions under current law and these would not be affected by the bill with respect to claims filed prior to enactment.

III. BUDGET EFFECTS OF THE BILL

1. COMMITTEE ESTIMATE

In compliance with clause 7(a) of Rules XIII of the Rules of the House of Representatives, the following statement is made: The Committee agrees with the cost estimate prepared by the Congressional Budget Office which is included below. This estimate indicates that there will be no costs associated with this bill.

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

With respect to clause 2(l)(3)(B) of Rule XI of the Rules of the House of Representatives, the Committee advises that the Congressional Budget Office cost estimate included below indicates that there is no new budget authority or new or increased tax expenditures as a result of this bill.

3. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by the CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 3, 1985.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 1868, as ordered reported by the Committee on Ways and Means on May 2, 1985. This bill amends the Social Security Act to protect beneficiaries under health care programs of that act from unfit care practitioners, and to otherwise improve the antifraud provisions of that act. The bill also amends the controlled Substances Act and the Social Security Act to deny, revoke, or suspend the registration to manufacture, distribute or dispense a controlled substance for entities excluded from reimbursement under the Medicare program.

Based on this review, it is expected that no additional cost to the government will be incurred as a result of enactment of this legislation. Although certain health care practitioners will be excluded from participation in Medicare, Medicaid, the Maternal and Child Health program, and Title XX Social Services, it is expected that beneficiaries will continue to receive the same level of services from other providers. This legislation is not expected to affect the budgets of state and local governments.

We would be pleased to respond to any questions you may have on this estimate. Your staff may contact Jack Rodgers (226-2820) with detailed questions.

With best wishes,

Sincerely,

RUDOLPH G. PENNER.

IV. OTHER MATTERS REQUIRED TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

1. VOTE OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of the Rule XI of Rules of the House of Representatives, the following statement is made: the bill H.R. 1868 was ordered favorably reported to the House of Representatives by voice vote.

2. OVERSIGHT FINDINGS

In compliance with clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, the Committee reports that the need for this legislation has been confirmed by the oversight findings of the Subcommittee on Health. As noted in the above Section on "Background and Need for Legislation," the General Accounting Office presented to the Subcommittee its findings based on its report of May 1, 1984, entitled "Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients from Health Practitioners Who Lose Their Licenses" (GAO/HRD-84-53). In preparing the report, the GAO reviewed license revocations and suspensions in three States and followed up on the practitioners to determine whether they were still receiving medicare and medicaid reimbursement. Many of the provisions included in this legislation resulted from the recommendations made by the GAO as a result of their investigation.

In addition, the Subcommittee took testimony from the Inspector General of the Department of Health and Human Services who has responsibility for enforcing the fraud and abuse laws designed to protect medicare and medicaid patients. The IG made recommendations to the Subcommittee to expand current authority to fill many of the gaps in current law. Many of these recommendations were included in H.R. 1868.

3. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(l)(3)(D) of Rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings and recommendations have been submitted to the Committee by the Committee on Government Operations with respect to the subject matter contained in the bill.

4. INFLATION IMPACT

Pursuant to clause 2(l)(4) of Rule XI of the Rules of the House of Representatives, with regard to the inflationary impact of the reported bill, the Committee believes that the bill has no measurable effect on health care prices or consumer prices generally.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 or rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

* * * * * * *

USE OF ALLOTMENT FUNDS

SEC. 504. (a) Except as otherwise provided under this section, a State may use amounts paid to it under section 503 for the provision of health services and related activities (including planning, administration, education, and evaluation) consistent with its description of intended expenditures and statement of assurances transmitted under section 505.

(b) Amounts described in subsection (a) may not be used for—

(1) inpatient services, other than inpatient services provided to crippled children or to high-risk pregnant women and infants and such other inpatient services as the Secretary may approve;

(2) cash payments to intended recipients of health services;

(3) the purchase or improvement of land, the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility, or the purchase of major medical equipment;

(4) satisfying any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; **[**or**]**

(5) providing funds for research or training to any entity other than a public or nonprofit private entity**[**.**]***; or*

(6) payment for any item or service furnished by an individual or entity excluded from participation in the program under this title pursuant to section 1128 or section 1128A.

The Secretary may waive the limitation contained in paragraph (3) upon the request of a State if the Secretary finds that there are extraordinary circumstances to justify the waiver and that granting the waiver will assist in carrying out this title.

(c) A State may use a portion of the amounts described in subsection (a) for the purpose of purchasing technical assistance from public or private entities if the State determines that such assistance is required in developing, implementing, and administering programs funded under this title.

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TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

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PART A—GENERAL PROVISIONS

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DISCLOSURE BY INSTITUTIONS, ORGANIZATIONS, AND AGENCIES OF OWNERS AND CERTAIN OTHER INDIVIDUALS WHO HAVE BEEN CONVICTED OF CERTAIN OFFENSES

SEC. 1126. (a) As a condition of participation in or certification or recertification under the programs established by titles XVIII, and XIX, any hospital, nursing facility, **[**or other institution, organization, or agency shall be required to disclose to the Secretary or to the appropriate State agency the name of any person who—

(1) has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency or is an officer, director, agent, or managing employee (as defined in subsection (b)) of such institution, organization, or agency, and

(2) has been convicted (on or after the date of the enactment of this section, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to the involvement of such person in any of such programs.**]** *or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person that is a person described in subparagraphs (A) and (B) of section 1128(b)(8).*

The Secretary or the appropriate State agency shall promptly notify the Inspector General in the Department of Health and Human Services of the receipt from any **[**institution, organization, or agency**]** *entity* of any application or request for such participation, certification, or recertification which discloses the name of any such person, and shall notify the Inspector General of the action taken with respect to such application or request.

(b) For the purposes of this section the term "managing employee" means, with respect to an **[**institution, organization or agency,**]** *entity,* an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the **[**institution, organization, or agency,**]** *entity,* or who directly or indirectly conducts the day-to-day operations of the **[**institution, organization, or agency.**]** *entity.*

* * * * * * *

EXCLUSION OF CERTAIN INDIVIDUALS CONVICTED OF MEDICARE- OR MEDICAID-RELATED CRIMES

[SEC. 1128. (a) Whenever the Secretary determines that a physician or other individual has been convicted (on or after October 25, 1977, or within such period prior to that date as the Secretary shall specify in regulations) of a criminal offense related to such individual's participation in the delivery of medical care or services under title XVIII, XIX, or XX, the Secretary—

[(1) shall bar from participation in the program under title XVIII each such individual otherwise eligible to participate in such program;

[(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) require each such agency to bar such individual from participation in such plan for such period as he shall specify, which in the case of an individual specified in paragraph (1) shall be the period established pursuant to paragraph (1);

[(B) may waive the requirement under subparagraph (A) to bar an individual from participation in a State plan under title XIX, where he receives and approves a request for such a waiver with respect to that individual from the State agency administering or supervising the administration of such plan; and

[(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such individual of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

[(b) Whenever the Secretary determines, with respect to an entity, that a person who has a direct or indirect ownership or control interest of 5 percent or more in the entity, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such entity, is a person described in section 1126(a), the Secretary—

[(1) may bar from participation in the program under title XVIII, for such period as he may deem appropriate, each such entity otherwise eligible to participate in such program;

[(2) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of the determination and may require each such agency to bar the entity from participation under the State plan for such period as he specifies, which may not exceed the period established pursuant to paragraph (1); and

[(3) shall promptly notify the appropriate State or local agency or authority having responsibility for the licensing or certification of such entity of the fact and circumstances of such determination, request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and request that such State or local agency or authority keep the Secretary and the Inspector General of the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to such request.

[(c) Whenever the Secretary makes a final determination to impose a civil money penalty or assessment against a person (including an organization, agency, or other entity) under section 1128A relating to a claim under title XVIII or XIX, the Secretary—

[(1) may bar the person from participation in the program under title XVIII, and

[(2)(A) shall promptly notify each appropriate State agency administering or supervising the administration of a State plan approved under title XIX of the fact and circumstances of such determination, and (except as provided in subparagraph (B)) may require each such agency to bar the person from participation in the program established by such plan for such period as he shall specify, which in the case of an individual shall be the period established pursuant to paragraph (1), and

[(B) may waive the requirement of subparagraph (A) to bar a person from participation in such program where he receives and approves a request for such waiver with respect to that person from the State agency referred to in that subparagraph.

[(d) A determination made by the Secretary under this section shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services furnished under title XVIII, such determination shall be effective in the manner provided in paragraphs (3) and (4) of section 1866(b) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

[(e) Any person or entity who is the subject of an adverse determination made by the Secretary under subsection (a), (b), or (c) shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).]

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program:

(1) CONVICTION OF PROGRAM-RELATED CRIMES.—Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program (as defined in subsection (h)).

(2) Conviction relating to patient abuse.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

(b) Permissive Exclusion.—The Secretary may exclude the following individuals and entities from participation in any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program:

(1) Conviction relating to fraud.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or financial abuse.

(2) Conviction relating to obstruction of an investigation.—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a).

(3) Conviction relating to controlled substance.—Any individual or entity that has been convicted, under Federal or State law, of unlawful manufacture, distribution, prescription, or dispensing of a controlled substance or other criminal offense relating to a controlled substance.

(4) License revocation or suspension.—Any individual or entity—

(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license, for reasons bearing on the individual's or entity's professional competence, professional conduct, or financial integrity, or

(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional conduct, or financial integrity.

(5) Exclusion from federal health care program.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under any Federal program, including programs of the Department of Defense or the Veterans' Administration, involving the provision of health care, or under a State health care program (as defined in subsection (h)).

(6) Claims for excessive charges or unnecessary services and failure of certain organizations to furnish medically necessary services.—Any individual or entity that the Secretary determines—

(A) has submitted or caused to be submitted bills or requests for payment under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished

substantially in excess of such individual's or entity's customary charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

(B) has furnished items or services to patients (whether or not eligible for benefits under title XVIII or a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

(C) is—

(i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under title XIX, or

(ii) an entity furnishing services under a waiver approved under section 1915(b)(1),

and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

(7) FRAUD, KICKBACKS, AND OTHER PROHIBITED ACTIVITIES.—Any individual or entity that the Secretary determines has committed an act which is described in section 1128A or section 1128B.

(8) ENTITIES CONTROLLED BY A SANCTIONED INDIVIDUAL.—Any entity with respect to which the Secretary determines that a person—

(A)(i) with an ownership or control interest (as defined in section 1124(a)(3)) in that entity, or

(ii) who is an officer, director, agents, or managing employee (as defined in section 1126(b)) of that entity—

is a person—

(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

(ii) against whom a civil monetary penalty has been assessed under section 1128A; or

(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

(9) FAILURE TO DISCLOSE REQUIRED INFORMATION.—Any entity that did not fully and accurately make any disclosure required of it by section 1124 or section 1126.

(10) FAILURE TO SUPPLY REQUESTED INFORMATION ON SUBCONTRACTORS AND SUPPLIERS.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary—

(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

(11) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing items or services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

(12) FAILURE TO GRANT IMMEDIATE ACCESS.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

(C) To the Inspector General of the Department of Health and Human Services, for the purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

(D) To a State medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

(13) FAILURE TO TAKE CORRECTIVE ACTION.—Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

Subject to subsection (d)(2), the Secretary shall exercise the authority under this subsection in a manner that results in an individual's or entity's exclusion from all the programs under title XVIII and all the State health care programs in which the individual or entity may otherwise participate.

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—An exclusion under this section or under section 1128A shall be effective

at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under title XVIII or under a State health care program for—

(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion, until the passage of 30 days after the effective date of the exclusion.

(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion under subsection (b)(12), the period) of the exclusion.

(B) In the case of an exclusion under subsection (a)(1), the minimum period of the exclusion may not be less than five years.

(C) In the case of an exclusion under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

(i) the length of the period in which the individual or entity failed to grant the immediate access described in that subsection, and

(ii) an additional period, not to exceed 90 days, set by the Secretary.

(d) NOTICE TO STATE AGENCIES AND EXCLUSION UNDER STATE HEALTH CARE PROGRAMS.—(1) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General)—

(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1128A, and

(B) the period (described in paragraph (2)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

(2)(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (1) shall be the same as any period of exclusion under a program under title XVIII.

(B) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (1) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

(e) NOTICE TO STATE LICENSING AGENCIES.—The Secretary shall—

(1) promptly notify the appropriate State or local agency or authority, having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A, of the fact and circumstances of the exclusion,

(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

(3) request that the State or local agency or authority keep the Secretary and the Inspector General in the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.

(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) Any individual or entity that is excluded (or directed to be excluded) from participation under this section (or is denied termination of the exclusion under subsection (g)) is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) The provision of section 205(h) shall apply with respect to this section and sections 1128A and 1156 to the same extent as it is applicable with respect to title II.

(g) APPLICATION FOR TERMINATION OF EXCLUSION.—(1) An individual or entity excluded (or directed to be excluded) from participation under this section (other than under subsection (b)(12)) or section 1128A may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1128A.

(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

(A) there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion, and

(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

(h) DEFINITION OF STATE HEALTH CARE PROGRAM.—For purposes of this section and sections 1128A and 1138B. the term "State health care program" means—

(1) a State plan approved under title XIX,

(2) any program receiving funds under title V or from an allotment to a State under such title, or

(3) any program receiving funds under title XX or from an allotment to a State under such title.

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity) that—

(1) presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (h)(1)), a claim (as defined in subsection (h)(2)) that [the Secretary determines is for a medical or other item or service—

[(A) that the person knows or has reason to know was not provided as claimed, or

[(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1128, 1160(b), or 1862(d), or pursuant to a determination by the Secretary under section 1866(b)(2) with respect to which the Secretary has initiated termination proceedings; or]

the Secretary determines—

(A) is for a medical or other item or service that the person knows or has reason to know was not provided as claimed,

(B) is for a medical or other item or service and the person knows or has reason to know the claim is false or fraudulent,

(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or has reason to know that the individual who furnished (or supervised the furnishing of) the service—

(i) was not licensed as a physician,

(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified, or

(D) is for a medical or other item or service furnished during a period in which the person was excluded under the program under which the claim was made pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1985), or 1866(b); or

(2) presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency *(or other requirement of a State plan under title XIX)* not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1), shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each item or service. In addition, such a person shall be subject to an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the United States or a

State agency because of such claim. *In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the programs under title XVIII and to direct the appropriate State agency to exclude the person from participation in any State health care program.*

(b)(1) The Secretary may initiate a proceeding to determine whether to impose a civil money penalty [or assessment], *assessment, or exclusion* under subsection (a) only as authorized by the Attorney General pursuant to procedures agreed upon by them. *The Secretary may not initiate an action under this section with respect to any claim later than six years after the date the claim was presented. The Secretary may initiate an action under this section by personal service or by mailing, by registered or certified mail, the notice required by paragraph (2).*

(2) The Secretary shall not make a determination adverse to any person under subsection (a) until the person has been given written notice and an opportunity for the determination to be made on the record after a hearing at which the person is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the person.

(c) In determining the amount or scope of any penalty [or assessment], *assessment, or exclusion* imposed pursuant to subsection (a), the Secretary shall take into account—

(1) the nature of claims and the circumstances under which they were presented,

(2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claims, and

(3) such other matters as justice may require.

* * * * * * *

(e) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1)(A) In the case of amounts recovered arising out of a claim under title XIX, there shall be paid to the State agency an amount [equal to the State's share of the amount paid by the State agency] *bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid*] for such claim.

* * * * * * *

(f) A determination by the Secretary to impose a penalty [or assessment], *assessment, or exclusion* under subsection (a) shall be final upon the expiration of the sixty-day period referred to in subsection (d). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to subsection (d) may not be raised as a defense to a civil action by the United States to collect a penalty [or assessment], *assessment, or exclusion* assessed under this section.

(g) Whenever the Secretary's determination to impose a penalty [or assessment], *assessment, or exclusion* under subsection (a) becomes final, he shall notify the appropriate State or local medical or professional organization, *the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),* and the appropriate utilization and quality control peer review organization, and the appropriate State of local licensing agency or organization (including the agency specified in section 1864(a) and 1902(a)(33)) that such a penalty [or assessment], *assessment, or exclusion* has become final and the reasons therefor.

* * * * * * *

(i) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II.

(j) Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, or encumbering assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.

[PENALTIES] *CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS*

SEC. [1909.] *1128B.* (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under [a State plan approved under this title,] *a program under title XVIII or a State health care program (as defined in section 1128(h)),*

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, [or]

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, *or*

(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a program under

title XVIII or a State health care program and knows that the individual who furnished the service either—

(A) was not licensed as a physician, or

(B) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing),

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under [this title,] *the program* be guilty of a felony and upon conviction thereof fined not more than $25,000, or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under [this title] *title XIX* is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of [this] *that* title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [this title,] *title XVIII or a State health care program,* or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [this title,] *title XVIII or a State health care program,*

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under [this title,] *title XVIII or a State health care program,* or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under [this title,] *title XVIII or a State health care program,* shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under [this title] *title XVIII or a State health care program,* if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under [this title] *title XVIII or a State health care program;* and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, [or home health agency (as those terms are employed in this title)] *home health agency, or other entity for which certification is required under title XVIII or a State health care program* shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under [this] title *XIX,* money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under [this] title *XIX,* any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

[The following subsection was previously subsection (d) of section 1877:]

[(d)] *(e)* Whoever accepts assignments described in section 1842(b)(3)(B)(ii) or agrees to be a participating physician or supplier under section 1842(h)(1) and knowingly, willfully, and repeatedly violates the term of such assignments or agreement, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $2,000 or imprisoned for not more than six months, or both.

PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

* * * * * * *

OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS OF HEALTH CARE SERVICES; SANCTIONS AND PENALTIES; HEARINGS AND REVIEW

SEC. 1156. (a) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under [title XVIII] *this Act,* to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under [such title] *this Act*—

(1) will be provided economically and only when, and to the extent, medically necessary;

(2) will be of a quality which meets professionally recognized standards of health care; and

(3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or person concerned, any organization having a contract with the Secretary under this part determines that such practitioner or person has—

(A) failed in a substantial number of cases substantially to comply with any obligation imposed on him under subsection (a), or

(B) grossly and flagrantly violated any such obligation in one or more instances,

such organization shall submit a report and recommendations to the Secretary. If the Secretary agrees with such determination, and determines that such practitioner or person, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under [title XVIII,] *this Act,* has demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, the Secretary (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such practitioner or person from eligibility to provide such services on a reimbursable basis. If the Secretary fails to act upon the recommendations submitted to him by such organization within 120 days after such submission, such practitioner or person shall be excluded from eligibility to provide services on a reimbursable basis until such time as the Secretary determines or otherwise.

(2) A determination made by the Secretary under this subsection to exclude a practitioner or person shall be effective at such time and upon such reasonable notice to the public and to the practitioner or person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in [title XVIII] *this Act* with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or person to provide such health care services on a reimbursable basis) such practitioner or person pays to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or person of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the practitioner or person from whom such amount is claimed.

(4) Any practitioner or person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(c) It shall be the duty of each utilization and quality control peer review organization to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organiation, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or person (referred to in subsection (a)) providing health care services in such area shall comply with all obligations imposed on him under subsection (a).

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

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USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

Sec. 1842. (a) * * *

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(j)(1) In the case of a physician who is not a participating physician, the Secretary shall monitor each such physician's actual charges to individuals enrolled under this part for physicians' services furnished during the 15-month period beginning July 1, 1984. If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under paragraph (1) are—

[(A) barring a physician from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d), or]

(A) excluding a physician from participation in the programs under this title for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128, or

(B) the imposition of civil monetary penalties and assessments, in the same manner as such penalties are authorized under section 1128A(a),

"or both. No payment may be made under this title with respect to any item or service furnished by a physician during the period when he is [barred from participation in the program] *excluded from participation in the programs* under this title pursuant to this subsection.

(3)(A) The Secretary may not [bar] *exclude* a physician pursuant to paragraph (2)(A) if such physician is a sole community physician or sole source of essential specialized services in a community.

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Part C—Miscellaneous Provisions

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Sec. 1862. (a) * * *

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[(d)(1) No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person—

[(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title;

[(B) has submitted or caused to be submitted (except in the case of a provider of services), bills or requests for payment under this title containing charges (or in applicable cases requests for payment of costs to such person) for services rendered which the Secretary finds to be substantially in excess of such person's customary charges (or in applicable cases substantially in excess of such person's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges (or in applicable cases, such costs); or

[(C) has furnished services or supplies which are determined by the Secretary on the basis of information acquired by the Secretary in the administration of this title to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care.

[(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, posthospital extended care services, and home health services such determination shall be effective in the manner provided in section 1866(b)(3) and (4) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

[(3) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[(4) The Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of any determination made under the provisions of this subsection.]

[(e) No payment may be made under this title with respect to any item or service furnished by a physician or other individual during the period when he is barred pursuant to section 1128 from participation in the program under this title.]

(e) No payment may be made under this title with respect to any item or service furnished by an individual or entity during any period when the individual or entity is excluded from participation in a program under this title pursuant to section 1128 or section 1128A.

* * * * * * *

(h)(1) * * *

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(4) The Secretary may deny payment under this title, in whole or in part and for such period of time as the Secretary determines to be appropriate, with respect to the implantation or replacement of a pacemaker device or lead of a manufacturer performed by a physician and provider of services after the Secretary determines (in accordance with the procedures established under [paragraphs (2) and (3) of subsection (d))] *subsections (c), (f), and (g) of section 1128)* that—

(A) the physician or provider of services has failed to submit information to the registry as required under paragraph (1)(C),

(B) the provider of services has failed to return devices and leads as required under paragraph (2)(A) or has improperly charged beneficiaries as prohibited under paragraph (2)(B), or

(C) the manufacturer of the device or lead has failed to perform and to report on the testing of devices and leads returned to it as required under paragraph (3).

(i) In order to supplement the activities of the Prospective Payment Assessment Commission under section 1886(e) in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1886(e)(6)(E) with respect to such a procedure if the Secretary finds that—

(1) such procedure is not of sufficient commercial value to justify research and experimentation by a commercial organization;

(2) research and experimentation with respect to such procedure is not of a type that may appropriately be carried out by an institute, division, or bureau of the National Institutes of Health; and

(3) such procedure has the potential to be more cost-effective in the treatment of a condition than procedures currently in use with respect to such condition.

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

[(3) The Secretary may refuse to enter into or renew an agreement under this section with a provider of services if any person who has a direct or indirect ownership or control interest of 5 percent or more in such provider, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such provider, is a person described in section 1126(a).]

[(b) An agreement with the Secretary under this section may be terminated—

[(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

[(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed (i) to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, or (ii) to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to such provider by the Secretary (I) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such provider has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (II) full and complete information as to any signficant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such provider and any wholly owned supplier or between such provider and any subcontractor, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary to be substantially in excess of the needs of individuals or to be of a quality which fails to meet professionally recognized standards of health care, or (G) that such provider (at the time the agreement was entered into) did not fully and accurately make any disclosure required of it by section 1126(a). [Any termination shall be applicable—

[(3) in the case of inpatient hospital services (including inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

[(4)(A) with respect to home health services or hospice care furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual more than 30 days after such effective date, and

[(5) with respect to any other items and services furnished on or after the effective date of such termination.]

(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to

the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, or

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A.

(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall be effective on the same date, and with respect to the same items and services, as an exclusion from participation under the programs under this title would become effective under section 1128(c).

(c)(1) Where [an agreement filed under this title by a provider of services has been terminated by the Secretary] *the Secretary has terminated or has refused to renew an agreement under this title with a provider of services,* such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination *or nonrenewal* has been removed and that there is reasonable assurane that it will not recur.

(2) In the case of a skilled nursing facility participating in the programs established by this title and title XIX, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1910(a), and the term of any such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section.

(3) Where an [agreement filed under this title by a provider of services has been terminated by the Secretary] has terminated or has refused to renew an agreement under this title with a provider of services, the Secretary shall promptly notify each State agency which administers or supervises the administration of a State plan approved under title XIX of such termination *or nonrenewal.*

(g)(1) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.

* * * * * * *

DETERMINATIONS; APPEALS

SEC. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title or section 1818, or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

[(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).]

* * * * * * *

[PENALTIES

[SEC. 1877. (a) Whoever—

[(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title.

[(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

[(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

[(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

[shall (i) in the cae of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.

[(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

[(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

[(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

[(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly, or covertly, in cash or in kind to any person to induce such person—

[(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

[(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

[(3) Paragraphs (1) and (2) shall not apply to—

[(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

[(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

[(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.]

[Subsection (d) of section 1877 was redesignated as subsection (e) and transferred and inserted in section 1128B after subsection (d).]

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. * * * (a)

*   *   *   *   *   *   *

(f)(1) The Secretary shall maintain, for a period ending not earlier than September 30, 1988, a system for the reporting of costs of hospitals receiving payments computed under subsection (d).

(2) If the Secretary determines, based upon information supplied by a utilization and quality control peer review organization under part B of title XI, that a hospital, in order to circumvent the payment method established under subsection (b) or (d) of this section, has taken an action that results in the admission of individuals entitled to benefits under part A unnecessarily, unnecessary multiple admissions of the same such individuals, or other appropriate medical or other practices with respect to such individuals, the Secretary may—

(A) deny payment (in whole or in part) under part A with respect to inpatient hospital services provided with respect to such an unnecessary admission (or subsequent admission of the same individual), or

(B) require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice.

[(3) The provisions of paragraphs (2), (3), and (4) of section 1862(d) shall apply to determinations under paragraph (2) of this subsection in the same manner as they apply to determinations made under section 1862(d)(1).]

(3) The provisions of subsections (c) through (g) of section 1128 shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1128(b)(13).

*   *   *   *   *   *   *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a). * * *

* * * * * * *

(23) except as provided in *subsection (g) and in* section 1915 and except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services;

* * * * * * *

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, **[**respectively, (A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom such entity has had, during the previous twelve months, business transactions in an aggregate amount in excess of $25,000, and (B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor;**]** *the information described in section 1128(b)(9);*

(39) provide that the State agency shall **[**bar**]** *exclude* any specified **[**person**]** *individual or entity* from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128 *or section 1128A,* and provide that no payment may be made under the plan with respect to any item or service furnished by such **[**person**]** *individual or entity* during such period.

* * * * * * *

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1912; **[**and**]**

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act**[**.**]** *; and*

(47) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1919.

* * * * * * *

(g)(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this title for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII under section 1128, 1128A, or 1866(b)(2).

(2) In order for a State to receive payments for medical assistance under section 1903(a), with respect to payments the State makes to as health maintenance organizations (as defined in section 1903(m)) or to an entity furnishing services under a waiver approved under section 1915(b)(1), the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

(A) could be excluded under section 1128(b)(8) (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions), or

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with individual or entity that is described in section 1128(b)(8)(B).

(3) As used in this subsection, the term "exclude" includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

[(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E) or (F) of section 1866(b)(2), or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38); or]

(2) with respect to any amount expended for items or services furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation in the State plan under this title pursuant to section 1128 or section 1128A; or

* * * * * * *

[(n) The State agency may refuse to enter into any contract or agreement with a hospital, nursing home, or other institution, organization, or agency for purposes of participation under the State plan, or otherwise to approve an institution, organizations, or agency for such purposes, if any person, who has a direct or indirect ownership or control interest of 5 percent or more in such institution, organization, or agency, or who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of such institution, organization, or agency, is a person described in section 1126(a) (whether or not such institution, organization, or agency has in effect an agreement entered into with the Secretary pursuant to section 1866); and, notwithstanding any other provision of this section, the State agency may terminate any such contract, agreement, or approval if it determines that the institution, organization, or agency did not fully and accurately make any disclosure required of it by section 1126(a) at the time such contract or agreement was entered into or such approval was given.]

* * * * * * *

PROVISION RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

* * * * * * *

[(2) restricts—

[(A) for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if the State has found, after notice, and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or

[(B) (through suspension or otherwise) for a reasonable period of time the participation of a provider of items or services under the State plan, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the provider has (in a significant number or proportion of cases) provided such items or services either (i) at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or (ii) of a quality which does not meet professionally recognized standards of health care.

if, under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.]

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assist-

ance for items or services under the State plan) can receive such items or services, if—

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

* * * * * * *

INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS

SEC. 1919. (a) INFORMATION REPORTING REQUIREMENT.—The requirement referred to in section 1902(a)(47) is that the State must provide for the following:

(1) INFORMATION REPORTING SYSTEM.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners or entities:

(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

(2) ACCESS TO DOCUMENTS.—The State must provide the Secretary (or an entity desgnated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this Act.

(b) FORM OF INFORMATION.—The information described in subsection (a)(1) shall be provided to the Secretary (or, under suitable arrangements made by the Secretary, to another entity) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information—

(1) to licensing authorities described in subsection (a)(1),

(2) to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),

(3) to utilization and quality control peer review organizations described in part B of title XI, and

(4) to State medicaid fraud control units (as defined in section 1903(q)),

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

(c) CONFIDENTIALITY OF INFORMATION PROVIDED.—The Secretary shall provide for suitable safeguards for the confidentiality of such of the information furnished under subsection (a) as is not otherwise available to the public.

TITLE XX—BLOCK GRANTS TO STATES FOR SOCIAL SERVICES

* * * * * * *

LIMITATIONS ON USE OF GRANTS

SEC. 2005. (a) Except as provided in subsection (b), grants made under this title may not be used by the State, or by any other person with which the State makes arrangements to carry out the purposes of this title—

(1) for the purchase or improvement of land, or the purchase, construction, or permanent improvement (other than minor remodeling) of any building or other facility;

(2) for the provision of cash payments for costs of subsistence or for the provision of room and board (other than costs of subsistence during rehabilitation, room and board provided for a short term as an integral but subordinate part of a social service, or temporary emergency shelter provided as a protective service);

(3) for payment of the wages of any individual as a social service (other than payment of the wages of welfare recipients employed in the provision of child day care services);

(4) for the provision of medical care (other than family planning services, rehabilitation services, or initial detoxification of an alcoholic or drug dependent individual) unless it is an integral but subordinate part of a social service for which grants may be used under this title;

(5) for social services (except services to an alcoholic or drug dependent individual or rehabilitation services) provided in and by employees of any hospital, skilled nursing facility, intermediate care facility, or prison, to any individual living in such institution;

(6) for the provision of any educational service which the State makes generally available to its residents without cost and without regard to their income;

(7) for any child day care services unless such services meet applicable standards of State and local law; **[**or**]**

(8) for the provision of cash payments as a service (except as otherwise provided in this section)**[**.**]***; or*

(9) for payment for any item or service furnished by a person excluded from participation in the program under this title pursuant to section 1128 or section 1128A.

(b) The Secretary may waive the limitation contained in subsection (a)(1) and (4) upon the State's request for such a waiver if he finds that the request describes extraordinary circumstances to justify the waiver and that permitting the waiver will contribute to the State's ability to carry out the purposes of this title.

* * * * * * *

SECTION 304, CONTROLLED SUBSTANCES ACT

DENIAL, REVOCATION, OR SUSPENSION OF REGISTRATION

SEC. 304. (a) A registration pursuant to section 303 to manufacture, distribute, or dispense a controlled substance may be suspended or revoked by the Attorney General upon a finding that the registrant—

(1) has materially falsified any application filed pursuant to or required by this title or title III;

(2) has been convicted of a felony under this title or title III or any other law of the United States, or of any State, relating to any substance defined in this title as a controlled substance;

(3) has had his State license or registration suspended, revoked, or denied by competent State authority and is no longer authorized by State law to engage in the manufacturing, distribution, or dispensing of controlled substances or has had the suspension, revocation, or denial of his registration recommended by competent State authority; **[**or**]**

(4) has committed such acts as would render his registration under section 303 inconsistent with the public interest as determined under such section **[**.**]** *; or*

(5) has been excluded (or directed to be excluded) from participation in a program pursuant to section 1128(a) of the Social Security Act.

A registration pursuant to section 303(g) to dispense a narcotic drug for maintenance treatment or detoxification treatment may be suspended or revoked by the Attorney General upon a finding that the registrant has failed to comply with any standard referred to in section 303(g).

* * * * * * *

SECTION 2373 OF THE DEFICIT REDUCTION ACT OF 1984

MISCELLANEOUS TECHNICAL AMENDMENTS

SEC. 2373. (a) * * *

* * * * * * *

(c)(1) The Secretary of Health and Human Services shall not take any compliance, disallowance, penalty, or other regulatory action against a State during the moratorium period described in paragraph (2) by reason of such State's plan *(whether or not approved)* under title XIX of the Social Security Act *(including any part of the plan operating pursuant to section 1902(f) of that Act), or the operation thereunder,* being determined to be in violation of section 1902(a)(10(C)(i)(III) of such Act on account of such plan's *(or its operation's)* having a standard or methodology which the Secretary interprets as being less restrictive than the standard or methodology required under such section.

(2) The moratorium period is the period beginning on the date of the enactment of this Act and ending 18 months after the date on which the Secretary submits the report required under paragraph (3).

(3) The Secretary shall report to the Congress within 12 months after the date of the enactment of this Act with respect to the appropriateness, and impact on States and recipients of medical assistance, of applying standards and methodologies utilized in cash assistance programs to those recipients of medical assistance who do not receive cash assistance, and any recommendations for changes in such requirements.

(4) No provision of law shall repeal or suspend the moratorium imposed by this subsection unless such provision specifically amends or repeals this subsection.

(5) In this subsection, a State plan is considered to include any amendment or other change in the plan which is submitted by a State, or for which the Secretary otherwise has notice, whether before or after the date of enactment of the Deficit Reduction Act of 1984 and whether or not the amendment or change was approved, disapproved, acted upon, or not acted upon by the Secretary.

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